STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155625	A. BUILDING 00 B. WING	02/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GROVE VILLAGE	1021 E CENTRAL AVE GREENSBURG, IN 47240

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00123230. Complaint IN00123230 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-309 and F-425. Survey dates: February 5, 6, 7, 8, 11 and 12, 2013 Facility number: 000305 Provided number: 155625 AIM number: 100287200 Survey team: Sharon Lasher RN, TC Angel Tomlinson RN Barbara Gray RN Leslie Parrett RN Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 8 Medicaid: 51 Other: 5 Total: 64	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after March 4, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2 Quality review 2/18/13 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician of a resident's significant weight loss for 1 of 26 residents reviewed for physician notification	F0157	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #52 no longer resides in the facility **How other**	03/05/2013

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	(Resident #52). Finding include: Review of the record of Resident #52 on 2-12-13 at 9:00 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure (CHF), anxiety, paraplegia and multiple sclerosis (MS). Resident #52 was admitted to the facility on 8-24-12 and weighed 126 pounds. The resident's weight on 8-30-12 was 115; this indicated a 8.7 % weight loss since admission. Resident #52's weight on 8-31-12 was 117. The Minimum Data Set (MDS) assessment for Resident #52, dated 8-31-12 indicated the resident was not on a physician prescribed weight loss regimen. Interview with the Director of Nursing on 2-12-13 at 9:25 a.m. indicated the physician was not notified of Resident #52's weight loss. Interview with the Dietary Manager on 2-12-13 at 10:15 a.m. indicated nursing was responsible to notify the physician of Resident #52's significant weight loss.		**residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.**Licensed nurses were educated on notifying a Physician for any resident with a significant weight loss, and to implement interventions to prevent weight loss by the DNS/designee on 2/28/2013. All residents were reviewed for significant weight loss by the DNS/designee. No other residents were identified.Residents identified with a significant weight loss or gain will be reviewed in weekly NAR meeting to include weight history, current nutrition regimen, oral status, observations during meals, root cause, plan of care updated, and physician and responsible party were notified - to be attended by the DM, RD if available, DNS, RSM, MDS Coordinator, and/or Designees. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses	

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	The weight policy, provided by the Administrator on 2-12-13 at 11:15 a.m., indicated the nursing department is responsible for identifying the resident with a significant unplanned weight loss/gain and meeting with the Dietary service Manager. The physician was also notified of significant or undesirable weight change. 3.1-5(a)(2)		were educated on notifying a Physician for any resident with a significant weight loss, and to implement interventions to prevent weight loss by the DNS/designee on 2/28/2013. Residents identified with a significant weight loss or gain will be reviewed in weekly NAR meeting to include weight history, current nutrition regimen, oral status, observations during meals, root cause, plan of care updated, and physician and responsible party notifed - to be attended by the DM, RD if available, DNS, RSM, MDS Coordinator, and/or Designees. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The CQI audit tool for resident weights will be utilized weekly for 4 weeks and then monthly for 6 months. ·Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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F0250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to provide social service assistance with a resident's code status when the resident's health had declined, resulting in the resident's code status being changed from a full code to a Do Not Resuscitate (DNR) by a person who was not authorized by the resident to make the decision of his code status, for 1 of 1 resident reviewed who met the criteria for death (Resident #90). Finding include: Review of the record of Resident #90 on 2-11-13 at 10:10 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, chronic airway obstruction and renal failure. Resident #90's record indicated the most current date the resident was admitted to the facility was on 9-16-12, and the resident passed away on 1-7-13.	F0250	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #90 no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice** Licensed nurses and Social Service Staff were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services on code status for residents, what constitues an authorized representative, updating face sheet when status changed and reporting to oncoming shift when status has changed. 100% audit was completed on residents current code status to ensure available to nursing staff by the Executive Director and SSD on 2/26/13. Any resident found to not have a current code status will immediately be updated by SSD/designee speaking to resident/responsible	03/05/2013

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	The admission record, dated 9-16-12 for Resident #90 indicated he was a full code (Cardiopulmonary Resuscitation [CPR] will done and any other life saving measures needed) and the name of the ex-spouse as an emergency contact person. The careplan for Resident #90, dated 8-8-12 indicated the resident had chosen life sustaining measures. The goal was the resident would receive CPR and an ambulance would be called. The interventions were assess resident for any condition changes, make resident comfortable and notify family of condition changes. The careplan for Resident #90, dated 8-8-12 indicated the resident planned on returning to the community. The goal was the resident would be discharged to home. The interventions were explore with the resident and family needs for transition to the community, keep resident and family apprised of progress toward discharge goals and offer home evaluation as appropriate. The social service progress note for Resident #90, dated 9-22-12 indicated the resident was able to make his own daily decisions as he is		party for information, physician notification, order obtained and resident face sheet and care plan updated. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee and SSD/designee are responsible to ensure compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses and Social Service Staff were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services on code status for residents, what constitutes an authorized representative, updating face sheet when status changed and reporting to oncoming shift when status has changed. 100% audit was completed on residents current code status to ensure available to nursing staff by the Executive Director and SSD on 2/26/13. Any resident found to not have a current code status will immediately be updated by SSD/designee speaking to resident/responsible party for information, physician notification, order obtained and resident face sheet and care plan updated. SSD/designee will ensure appropriate paperwork is available to designate resident specific authorized representative. ED/designee will	

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	able to make his self understood with a clear spoken voice and understands others. The resident was at the facility for a short term stay and plans on returning home. The resident was a full code status. The social service progress note for Resident #90, dated 11-13-12 indicated the resident was able to make his own daily decisions and make himself understood as well as understood others. The resident was at the facility for a short term stay and was a full code status. The social service progress note for Resident #90, dated 12-31-12 indicated the resident was able to make his own daily decisions. The resident was in the facility for a long term stay and was a full code status. The social service progress note for Resident #90, dated 1-7-13 indicated the resident's code status form was signed and dated. The code status form was sent to the physician for a signature. Review of the "State of Indiana out of hospital Do Not Resuscitate declaration and order" indicated Resident #90's code status was changed to DNR on 1-7-13. The form		review POA paperwork when there is a change in CPR/DNR status to ensure appropriate paperwork is consistent with current authorized representative. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee and SSD/designee are responsible to ensure compliance**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI tool for advanced directives will be utilized weekly for 4 weeks and then monthly for 6 months.· Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	had the resident's name on it and was witnessed by LPN #1. The progress note for Resident #90, dated 1-7-13 at 11:30 p.m. indicated the resident had expired. Interview with the Social Service Director (S.S.D.) on 2-11-13 at 10:30 a.m. indicated Resident #90's ex spouse gave the approval to change the resident's code status from a full code to a DNR and signed his name on 1-7-13, the same day he passed away. The S.S.D. indicated the ex spouse made the choice for the resident after his health declined. The S.S.D. indicated the resident was a full code and had planned on being discharged to home. The S.S.D. indicated the resident's health had slowly declined. The S.S.D. indicated there was no documentation that the resident had wanted his ex spouse to be his health care representative or Power Of Attorney (POA). The S.S.D. indicated she did not realize there was no legal paperwork appointing the ex spouse to be the resident's health care representative or POA to make the decision. The S.S.D. indicated the ex spouse told her that she would take over the resident's health care decisions.			

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	Interview with LPN #1 on 2-11-13 at 10:45 a.m. indicated she had witnessed Resident #90's DNR code status change and signed it. LPN #1 indicated the resident's ex spouse was the one who signed the resident's name. LPN #1 indicated the ex spouse did not tell the facility she was the resident's health care representative or POA. The "Advanced Directives and Residents Rights to Refuse Medical Treatment" provided by the Administrator on 2-12-13 at 11:15 a.m. indicated "where a resident no longer has capacity and someone else seeks to act on resident's behalf, facility must verify the legal standing or authority of the representative who wishes to obtain the DNR order." "Subject to state law, authority may be/have been granted to the representative in a number of ways: POA for healthcare, guardianship, Durable Power of Attorney, spouse, surviving parents, adult children and surviving siblings." 3.1-34(a)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow a resident's Restorative Plan of Care, for 1 of 26 residents reviewed for care plans. (Resident #97) Findings include: Resident #97's record was reviewed on 2/7/13 at 2:41 P.M. Resident #97 was admitted to the facility on 10/24/12. His diagnoses included, but were not limited to, cerebral palsy, peripheral neuropathy, osteoarthritis-multiple sites, and pain in his joints including the forearm, pelvis, and thigh. He had one fall. Resident #97's quarterly MDS (Minimum Data Set) assessment dated 1/21/13, indicated he was understood and understood others. His Brief Interview for Mental Status score was 15, indicating he was cognitively intact. He required supervision of 1 person to transfer. He walked in his room. He required supervision and set up only for toilet use. He had no functional limitations	F0282	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #97 is recieving restorative services per residents restorative plan of care **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.**Restorative c.n.a.'s were educated on following a residents restorative plan of care and completing the restorative flowsheet on 3/1/13 by the MDS Coordinator/designee. All restorative programs were reviewed with restorative CNA's to ensure that restorative CNA's were educated on current restorative plans by the MDS Coordinator on 3/1/13.The MDS Coordinator/designee is responsible to monitor for compliance. Non-compliances with these procedures will result in further staff training including disciplinary action if necessary. **What measures will be put into**	03/05/2013

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	for his range of motion in his upper or lower extremities. He utilized a walker and wheelchair. A PT (Physical Therapy) Progress and Discharge Summary for Resident #97 dated 1/21/13, for the time period of 10/25/12 until 1/21/13, indicated the following: "Discharge Plans: to stay in facility with restorative program." An OT (Occupational Therapy) Progress and Discharge Summary for Resident #97 dated 2/1/13, for the time period of 1/17/13 until 2/1/13, indicated the following: "Discharge Plans: RNP" (Restorative Nursing Program). A Restorative Flowsheet indicated the following order for Resident #97, initiated on 1/24/13: Resident #97 would walk 200 feet, 6 days a week, using a rolling walker with standby assistance. The Restorative Flowsheet indicated Resident #97 had participated for 15 minutes on January 25, 28, 29, 30, and 31, 2013. Resident #97 had participated for 15 minutes on February 1, 4, 5, 6, 7, and 8, 2013. A Restorative Flowsheet indicated the following order for Resident #97,		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** Restorative c.n.a.'s were educated on following a residents restorative plan of care and completing the restorative flowsheet on 3/1/13 by the MDS Coordinator/designee. All new restorative programs will be reviewed with the restorative c.n.a.'s by the MDS Coordinator/designee prior to the initiation of the program.MDS Coordinator/Manager on Duty will conduct rounds Monday through Saturday to ensure the restorative care plan is followed for residents participating in restorative care.The MDS Coordinator/designee is responsible to monitor for compliance. Non-compliances with these procedures will result in further staff training including disciplinary action if necessary. **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI tool for restorative nursing (Fit Program) will be utilized weekly for 4 weeks then monthly for 6 months. Findings from the CQI process will be reviewed by the Quality Assurance Committee monthly and an action plan will be implemented for threshold below 90%.	

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	initiated on 1/24/13. Resident #97 would perform 40 AROM (active range of motion) exercise repetitions to his bilateral upper extremities, using 2 pound weights, 6 days a week. The Restorative Flowsheet indicated Resident #97 had participated for 15 minutes on January 25, 28, 29, 30, and 31, 2013. Resident #97 had participated for 15 minutes on February 1, 4, 5, 6, 7, and 8, 2013. On 2/7/13 at 10:37 A.M., Resident #97 was observed lying in bed watching TV. He indicated he was no longer in therapy. He indicated he utilized a walker and a wheelchair. He indicated he could walk about anywhere in the building using his walker, and he did ambulate with his walker sometimes, but he was becoming more dependent on his wheelchair. On 2/7/13 at 12:09 P.M., Resident #97 was observed propelling his wheelchair from the dining room to his bedroom, using his bilateral feet. He stated "yeah, I took the wheelchair to lunch today." On 2/8/13 at 10:06 A.M., Resident #97 indicated when he was admitted to the facility he could hardly walk and			

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	therapy concentrated mainly on his lower extremities. He indicated he was not currently in any exercise program and he sometimes walked down the hallway using his walker by himself. He indicated he did not walk using his walker with any of the staff. He indicated he knew he should not be waking down the hallway using his walker without staff with him. He indicated he did not do any arm exercises "except getting in and out of bed." On 2/8/13 at 10:30 A.M., Restorative Aide #4 indicated she worked Monday through Friday and Restorative Aide #5 worked Sunday through Thursday. She indicated Resident #97 was on Restorative Aide #5's case load but she worked with Resident #97 when she was off. She indicated she made sure he was walked. She indicated he also performed his arm exercises in his room, including his wrist, and fingers. She indicated he did not use any weights when he performed his arm exercises. On 2/8/13 at 10:50 A.M., Restorative Aide #4 was observed walking with Resident #97 down the hallway from his bedroom to the dining room. She was holding onto a gait belt around			

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	his waist, and he utilized a rolling walker. On 2/11/13 at 10:16 A.M., Restorative Aide #5 indicated she had been walking Resident #97 in the hallway 200 feet a day. She indicated she used a gait belt and he utilized a walker. She indicated Resident #97 also performed AROM to his upper and lower extremities. She indicated she did not use any weights with him during his exercises. She indicated she knew a resident's Restorative plan of care by looking at the order on the Restorative Flowsheet. She indicated she documented Resident #97's participation on the Restorative Flowsheet. She indicated she did not realize he was supposed to use weights "until I looked at the Restorative Flowsheet just now." "I just overlooked the 2 pound weight on the Restorative Flowsheet for AROM." On 2/11/13 at 10:45 A.M., Resident #97 indicated occasionally staff walked down the hallway with him when he used his walker but not very often. "I'm not supposed to walk by myself. I used to be in therapy and they walked with me." He indicated no staff came into his room and had him exercise his arms or legs. "I			

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	could do that by myself if I wanted to, but I haven't been." A Restorative Nursing Program policy and procedure provided by the Administrator on 2/12/13 at 3:25 P.M., indicated the following: "Purpose-To provide a nursing program for residents who no longer need skilled therapy, but still have functional goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment. These programs facilitate the use of skills that are present but not utilized unless compensations or adaptations are provided and designed to foster maximum independence in functional activities.. Process-The program is coordinated, supervised and carried out by nursing staff preferably the MDS coordinator or MDS assistant.. Program documentation-...C.N.A. will document on the "Monthly Summary Grid" the number of minutes the program was provided and their initials. Restorative nursing programs include-Active or Passive range of motion... Walking or Bed Mobility...." 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A.) Based on interview, observation and record review, the facility failed to administer, assess and treat pain in a timely manner for 2 of 3 residents reviewed for pain of 5 residents who met the criteria for pain. (Resident #A and #E) B.) Based on interview and record review, the facility failed to have a resident's advanced directive available for the facility nursing staff, resulting in CPR (Cardiac Pulmonary Resuscitation) being initiated for a resident who was a DNR (Do Not Resuscitate) code status for 1 of 1 resident reviewed who met the criteria for death. (Resident #90) Findings include: A.1.) The record of Resident #A was reviewed on 2/7/13 at 9:24 a.m. Resident #A's diagnoses included, but were not limited to, MRSA (Methicillin-Resistant-Stephylococcus Aureus), of the lungs, insomnia,	F0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident A no longer resides in the facility.Resident B pain has been assessed for pain and is recieving pain medication timely per orderResident # 90 no longer resides in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practices**All residents were assessed for pain by the DNS/designee. Any resident indicating pain, physician was notified for potential new physician orders, responsible was also notified, and the resident's plan of care was updated.Licensed nurses were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services on assessing residents with	03/05/2013

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	pleural effusion (excess fluid between the 2 pleural layers of the lungs) and depressive disorder. Resident #A's MDS (Minimum Data Set), assessment, dated 1/15/13, indicated the following: - BIMS (Brief Interview for Mental Status), 15, a score of 13-15 indicating cognition intact - pain presence, yes - on scheduled pain medication, no - on PRN (as needed), pain medication, yes - pain frequency, almost constant - has pain made it hard for you to sleep at night, yes - pain intensity, moderate - should staff conduct a pain assessment, no Resident #A's care plan, dated 1/9/13, indicated "Problem, Resident has pain related to, complaint of back pain and post surgical pain. Goal, Will have relief of pain within 30-60 minutes of intervention. Intervention, Administer medication as ordered, non-medication interventions such as rest, quiet environment, therapies as ordered and notify physician if pain is unrelieved and/or worsening." Resident #A's pain assessment, dated 1/9/13, indicated "are you		complaints of pain and administering pain medication to provide necessary care and services timely.Any resident complaining of increased or decreased pain will have a pain assessment completed, interventions initiated, MD/responsible party notified, pain medication administered per order and plan of care updated, effectivness of any PRN pain medication will also be documented in the progress notes. This will be monitored by the facility activity report by the DNS/designee.Licensed nurses were in-serviced on 2/28/13 by the Executive Director and Director of Nursing Services on code status for residents, updating face sheet when status changed and reporting to oncoming shift when status has changed.100% audit was completed on 2/26/2013 on resident's current code status to ensure available to nursing staff by the Executive Director and SSD. Any resident found to not have a current code status will immediately be updated by SSD/designee speaking to resident/responsible party for information, order obtained and resident face sheet and care plan updated. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure	

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	currently experiencing pain, yes. Have you had pain or hurting at any time in the last 5 days, yes. Over the past 5 days, has pain made it hard for you to sleep at night, yes. Over the past 5 days, have you limited your day-to-day activities because of pain, yes . What is the location of your pain, back. Please rate the intensity of your worst pain over the last 5 days, moderate. How much of the time have you experienced pain or hurting over the last 5 days, almost constantly. Type of pain, aching." Resident #A's physician's order, dated 1/9/13 at 10:09 a.m., faxed to the pharmacy " Percocet (narcotic analgesic) 5 mg (milligrams) -acetaminophen (Tylenol), 325 mg, oral tablet, 1-2 tablets oral every 4 hours PRN pain." Resident #A's nursing notes indicated the following: - 1/9/13 at 5:35 p.m., resident has surgical drain sites on back, there are stitches, there is no drainage or redness - 1/9/13 at 6:15 p.m., resident appears at Arbor Grove Village accompanied by friend and ambulance crew...resident requested pain medication upon arrival		compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses were in-serviced on 2/28/13 by the Executive Director and the Director of Nursing Services on assessing residents with complaints of pain and administering pain medication to provide necessary care and services timely.Any resident complaining of increased or decreased pain will have a pain assessment completed, interventions initiated, MD/responsible party notified, pain medication administered per order and plan of care updated, effectivness of any PRN pain medication will also be documented in the progress notes. This will be monitored via the facility activity report by the DNS/designee.Licensed nurses were in-serviced on 2/28/13 by the Executive Director and Director of Nursing Services on code status for residents, updating face sheet when status changed and reporting to oncoming shift when status has changed.100% audit was completed on 2/26/2013 on resident's current code status to ensure available to nursing staff by the Executive Director and SSD. Any resident found to not have a current code status will	

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	Resident #A's MAR (Medication Administration Record), from the local hospital, dated 1/9/13 at 12:39 p.m., indicated Resident #A received Percocet 5 mg/acetaminophen 325 mg, 2 tablets, by mouth, with a pain rating at 6 on a pain scale of 0-10. Resident #A's MAR at the facility, dated 1/10/13 at 12:01 a.m., indicated Percocet 5 mg/325 mg acetaminophen, 1 tablet given for complaint of pain. During an interview on 2/11/13 at 2:58 p.m., the DON (Director of Nursing) indicated Resident #A had not received pain medication from 1/9/13 at 12:39 p.m. to 1/10/13 at 12:01 a.m. She also indicated the facility had Percocet 5/325 in their EDK (Emergency Drug Kit) and the pharmacy had the required prescription to dispense the medication before Resident #A was admitted to the facility. A. 2.) During observation on 2-6-13 at 9:37 a.m. Resident #E was groaning and had facial grimacing. Resident #E indicated she was hurt from a fall. Resident #E indicated it hurt to walk. During observation on 2-7-13 at 9:55 a.m. Resident #E was being transferred from her bed to a		immediately be updated by SSD/designee speaking to resident/responsible party for information, order obtained and residetn face sheet and care plan updated. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The CQI tool for pain management and advanced directives will be utilized weekly for 4 weeks and then monthly for 6 months.· Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	wheelchair with the assistance of CNA#3. The resident stated during the transfer "ouch" and pointed to her pelvic area and said it hurt. The resident had facial grimacing during the transfer. CNA #3 indicated before the resident had a fall she walked with a walker, and since she fell the resident had been using the wheelchair. Resident #E indicated it was easier for her to use the wheelchair because hurt when she walked with the walker. Interview with Resident #E's family member on 1-8-13 at 9:50 a.m. indicated the resident did complain about being in pain. The family member indicated they tell the resident to ask for pain medicine if she is in pain. Review of the record of Resident #E on 2-7-13 at 11:45 a.m. indicated the resident's diagnoses included, but were not limited to, dementia, hypertension, osteoporosis, shortness of breath, anemia, cerebral vascular accident (CVA) (stroke), anxiety and coronary artery disease. The Minimum Data Set (MDS) assessment for Resident #E, dated 11-3-12 indicated the resident walked in her room and corridor with limited			

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	assistance of one person, the resident had occasionally had pain and the pain had made it hard for her to sleep at night. The resident's pain was moderate. The safety event documentation for Resident #E, dated 1-23-13 indicated the resident had an unwitnessed fall. The progress note for Resident #E, dated 1-25-13 at 11:39 a.m. indicated the resident started dragging her right leg and complained of pain in her right leg. The resident had some bruising on the back of her right leg. A fax was sent to the physician to ask for an x ray of her right hip and pelvis. The progress note for Resident #E, dated 1-25-13 at 11:27 p.m. indicated the resident continued to complain of pain in her leg and bottom. The progress note for Resident #E, dated 1-26-13 at 9:14 p.m. indicated the resident still was voicing complaints of being sore and not feeling well. The progress note for Resident #E, dated 1-30-13 indicated the resident's x-rays were negative for any fractures.			

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	The careplan for Resident #E, dated 1-30-13 indicated the resident had occasional complaints of moderate pain. The pain assessment for Resident #E, dated 1-30-13 indicated the resident had pain in the past 5 days. The resident rated it as moderate pain. The resident described her pain as an aching pain. The resident had chronic pain. Interview with the Memory Care Program Director on 2-11-13 at 9:30 a.m. indicated there was no pain medication given to the resident on 1-25-13 or 1-26-13 when the resident experienced pain. The Memory Care Program Director indicated there were no non-pharmaceutical pain interventions documented for 1-25-13 or 1-26-13 when the resident was experiencing pain. The Memory Care Program Director indicated there was no plan of care for pain or pain assessment for Resident #E until 1-30-13 because the resident did not really have a supportive diagnosis for pain. The pain management policy provided by the Director Of Nursing on 2-11-13 at 2:00 p.m. indicated it was the facility policy to provide			

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	necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. B. 1.) Review of the record of Resident #90 on 2-11-13 at 10:10 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure, anemia, hypertension, chronic airway obstruction and renal failure. Resident #90's record indicated the most current date the resident was admitted to the facility was on 9-16-12 and the resident passed away on 1-7-13. The admission record, dated 9-16-12 for Resident #90 indicated he was a full code (Cardiopulmonary Resuscitation [CPR] will done and any other life saving measures needed) and the name of the ex spouse as an emergency contact person. The careplan for Resident #90, dated 8-8-12 indicated the resident had chosen life sustaining measures. The goal was the resident would receive CPR and an ambulance would be called. The interventions were assess			

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	resident for any condition changes, make resident comfortable and notify family of condition changes. The careplan for Resident #90, dated 8-8-12 indicated the resident planned on returning to the community. The goal was the resident would be discharged to home. The interventions were explore with the resident and family needs for transition to the community, keep resident and family apprised of progress toward discharge goals and offer home evaluation as appropriate. The social service progress note for Resident #90, dated 1-7-13 indicated the resident's code status form was signed and dated. The code status form was sent to the physician for a signature. Review of the "State of Indiana out of hospital Do Not Resuscitate declaration and order" indicated Resident #90's code status was changed to DNR on 1-7-13. The form had the resident's name on it and was witnessed by LPN #1. The documentation indicated the fax was returned with the physician's signature on 1-7-13 at 3:53 p.m. The progress note dated, 1-7-13 for			

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	Resident #90 indicated the resident was found to be unresponsive, no pulse and no respirations. The nurse called for assistance from another nurse and began CPR. The Emergency Medic Team 911 was called. The EMT's arrived at the facility and took over CPR for the resident. The EMT asked what the resident's code status was and once the EMT's noted the resident was a DNR code status they ceased CPR and pronounced the resident deceased at 11:38 p.m. The progress note was signed by LPN #2. Review of the Physician order for Resident #90's code status indicated the resident's code status was changed to a DNR. The order was changed from a full code to DNR on 1-7-13 at 11:58 p.m. Interview with the Director Of Nursing on 2-11-13 at 10:55 a.m. indicated the fastest way a nurse can tell what a resident's code status was to look at the face sheet in the computer. Interview with LPN #1 on 2-11-13 at 10:45 a.m. indicated the order for resident's code status had been faxed to the physician on 1-7-13 on day shift. LPN #1 indicated the second shift nurse should have received the			

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	fax. When queried about the date and time on the DNR fax order was 1-7-13 at 3:53 p.m. on day shift, LPN #1 indicated she did not know it had come back and the second shift nurse should have seen it in the resident's chart. LPN #1 indicated she did not know if the second shift nurse had been told in shift report that Resident #90's code status had been changed to a DNR. LPN #1 indicated it should have been reported in shift report to the second shift nurse. Interview with LPN #2 on 2-11-13 at 12:50 p.m. indicated he initiated CPR on Resident #90 on 1-7-13. LPN #2 indicated he had not been told in report that the resident's code status order had been received for the resident to be a DNR. LPN #2 indicated he was told in shift report that a fax had been sent to the physician, but it had not come back to the facility. LPN #2 indicated he started his shift on 1-7-13 at 6:00 p.m. LPN #2 indicated he looked at Resident #90's electronic health file and the resident chart and the resident was still a full code, so he initiated CPR on 1-7-13 because he could only go by what the resident's record said. LPN #2 indicated he had another nurse help him look for the resident's DNR order and they were			

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	unable to locate it either. LPN #2 indicated after EMT's arrived and took over CPR, he went searching for the DNR order again and found it in the hospice book in the nursing station. LPN #2 indicated he then went and told EMT's that the resident was a DNR and they ceased CPR on the resident. LPN #2 indicated he had tried to figure out if the resident was a full code before he initiated CPR and call EMT's, but the resident's records indicated he was a full code. LPN #2 indicated after he found the physician order for the DNR he went into the computer and changed the resident's code status from full code to DNR. This federal tag relates to complaint IN00123230. 3.1-37(a)			

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	155625	A. BUILDING 00 B. WING	02/12/2013

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F0312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to provide 2 residents with clean, trimmed, nails, for 2 of 4 residents sampled for ADL's (activities of daily living), of 16 who met the criteria for ADL's. (Resident #26 and #103). Findings include: 1.) Resident #26's record was reviewed on 2/11/13 at 12:05 P.M. Her diagnoses included but were not limited to Parkinsonism, osteoarthrosis, myalgia, dementia, psychosis, congestive heart failure, chronic obstructive pulmonary disease, and diabetes. Resident #26's significant MDS (Minimum Data Set) assessment dated 11/29/12, indicated she understood, and had the ability to understand others. She scored 7 on her Brief Interview for Mental Status, indicating she was cognitively impaired. She required extensive assist of 2 persons for bed mobility,	F0312	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident # 26 fingernails are clean and trimmed**Resident # 103 no longer resides at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice.All resident's nails were observed and cleaning/trimming was performed as needed by DNS and ADNS on 2/13/13.Nursing staff were in-serviced on 2/28/13 on providing ADL care for residents who are unable to carry out activities of daily living by the ED and DNS.**Residents that are unable to carry out activities of daily living will have their fingernails observed by nursing staff at least 2 times weekly during showers and prn to ensure nails are clean and trimmed, those residents that are diabetic will have nails	03/05/2013

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	transfer, and toileting. She required extensive assist of 1 person to walk in her room, eat, dress, and personal hygiene. A Care Plan for Resident #26 reviewed 11/29/12, indicated she received hospice services. An approach on her Care Plan indicated she would be cared for by the facility staff as well as Hospice staff. On 2/7/13 at 11:21 A.M., Resident #26 was seated in her wheelchair in the assisted dining room with peers. Resident #26 had no nail on her thumb or little finger of her left hand and no nail on her thumb of the right hand. Her nails were long, jagged, and discolored yellow. An interview with CNA #7 on 2/7/13 at 11:36 A.M., indicated if a resident was a diabetic, the nurses cared for their nails. She indicated some of Resident #26's nails were long and jagged and they were discolored yellow. An interview with RN #8 on 2/7/13 at 12:13 P.M., indicated Resident #26 was a diabetic and the nurses would be responsible for her nail care. RN #8 indicated Resident #26 was Hospice and the Hospice Aides gave		trimmed by a licensed nurse. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff were in-serviced on 2/28/13 on providing ADL care for residents who are unable to carry out activities of daily living by the ED and DNS.**Residents that are unable to carry out activities of daily living will have their fingernails observed by nursing staff at least 2 times weekly during shower and prn to ensure nails are clean and trimmed, those residents that are diabetic will have nails trimmed by a licensed nurse. This will be monitored by the DNS/designee via shower sheets and nail care documentation. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI tool for accommodation of needs will	

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	Resident #26 a shower 2 times a week. She indicated the Hospice nurse saw Resident #26 at least weekly. She indicated if the Hospice nurse did not provide Resident #26 with her nail care, it would be the facility's responsibility. RN #8 said she had just clipped Resident #26's nails and they were long and jagged. On 2/7/13 at 12:15 P.M., Resident #26 indicated the nurse had just clipped her nails. Resident #26's nails were observed to be clipped to an appropriate length and clean at that time. 2.) Resident #103's record was revived on 1/12/13 at 1:45 P.M. Resident #103 was admitted to the facility on 1/16/13. His diagnoses included but was not limited to Parkinsonism, chronic obstructive pulmonary disease, osteoarthrosis, rheumatoid arthritis, joint pain, muscle weakness, diabetes, and clostridium difficile. Resident #103's admission MDS assessment dated 1/23/13, indicated he made himself understood, but rarely understood others. He required extensive assistance of 2 persons for transfers, bed mobility, and toileting. He required total dependence of 2		be utilized weekly for 4 weeks and then monthly for 6 months.· Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	persons for dressing. He required extensive assistance of 1 person for personal hygiene. He did not walk. He was incontinent of bowel and bladder. On 2/5/13 at 11:44 A.M., Resident #103 was observed lying in bed. He had long fingernails and there was dark substance underneath the nails, which was more prominent under his thumb and first finger nail of his left hand. On 2/5/13 at 11:57 A.M., CNA #9 indicated she did not know why Resident #103's nails had not been trimmed. She indicated his nails may be dirty because he dug at his private areas. She indicated his nails were long and had been since he was admitted. 3.1-38(a)(3)(E)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement fall interventions for 1 of 4 residents reviewed for accidents, for 6 who met the criteria for accidents. (Resident #39) Findings include: Resident #39's record was reviewed on 2/8/13 at 10:39 A.M. Her diagnoses included but was not limited to psychosis, senile dementia with depression, osteoarthrosis, and subdural hematoma. Fall Event Reports for Resident #39 indicated the following: Event date: 12/13/12 at 4:55 P.M.-Resident #39 had an unwitnessed fall. She was first observed lying face down in the main dining room. She had a hematoma to her forehead. Interventions put into place to prevent another fall included OT (Occupational Therapy) and PT (Physical Therapy) would evaluate Resident #39 and she would	F0323	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #39 no longer resides at the facility.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice**Nursing staff were re-educated on 2/28/13 on fall policy/procedure/interventions by the ED and DNS.An audit was completed on all fall risk residents to ensure interventions were in place and functioning, and that their care plan and c.n.a. assignment sheet were updated. This will be completed by the IDT by 3/4/2013. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance**What measures will be put into place or what**	03/05/2013

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	ambulate with 1 assist. Event date: 12/14/12 at 9:20 P.M.-Resident #39 had an unwitnessed fall. She had been trying to turn her TV off and was unable to, so she went to get help. She was observed lying in the hallway outside her bedroom on her right side, fully clothed, with no shoes on. Interventions put into place to prevent another fall included a pressure alarm was placed in her bed. Event date: 12/15/12 at 10:31 A.M.-Resident #39 had an unwitnessed fall. She had been trying to sit in her recliner. She was observed sitting in her bedroom on her buttock. She had on underwear and shoes, but no pants. Interventions put into place to prevent another fall included her chair would be placed back against the wall so it could not slide. She would have a personal alarm. Event date: 12/16/12 at 5:55 P.M.-Resident #39 had an unwitnessed fall. She was observed lying on her bathroom floor. She received a bump to the top of her head. Interventions put into place to prevent another fall included a floor mat alarm. Event date: 12/21/12 at 4:40 P.M.-Resident #39 had an unwitnessed fall. She was observed sitting in front of her recliner, fully clothed, with her shoes on. She was placed in her recliner with a pressure alarm. When she was found on the		**systemic changes will be made to ensure that the deficient practice does not recur?** Nursing staff were re-educated on 2/28/13 on fall policy/procedure/interventions by the ED and DNS.An audit was completed on all fall risk residents to ensure interventions were in place and functioning, and that their care plan and c.n.a. assignment sheet were updated. This will be completed by the IDT by 3/4/2013. Rounds will be completed daily by the DNS/designee to ensure that fall interventions are in place according to the resident's plan of care. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The CQI audit tool for fall management will be utilized weekly for 4 weeks then monthly for 6 months. ·Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	floor the alarm box was on the wheelchair and the pad was still in her recliner. Interventions put into place to prevent another fall included the Dr. was there and would evaluate her. The alarm box would be placed out of her reach. Resident #39's significant change MDS (Minimum Data Set) assessment dated 12/27/12, indicated she understood and was able to understand others, she scored 4 on her Brief Interview for Mental Status, indicating her cognitive status was severely impaired. She required extensive assistance of 2 persons for bed mobility, transfers, to walk in her room, dressing, toileting, and personal hygiene. She was only able to stabilize with human assistance to: 1. Move from a seated to standing position. 2. Walk (with and assistive device if used). 3. Turning around and facing the opposite direction while walking. 4. Moving on and off the toilet. 5. Surface to surface transfers (transfer between the bed and chair or wheelchair). She utilized a walker and a wheelchair. She had 2 or more falls. A Care Plan for Resident #39 dated 1/17/13, indicated the following: Resident #39 had an acute change in			

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	her baseline mental status due to a chronic subdural hematoma. Resident #39's goal was to return to her previous mental status. Fall Event Reports for Resident #39 indicated the following: Event date: 1/28/13 at 2:33 P.M.-Resident #39 had a witnessed fall. She was being assisted to the restroom and was assisted to the floor. She was fully clothed with her shoes on. Interventions put into place to prevent another fall included assist times 2. A Care Plan for Resident #39 dated 12/4/12 and updated 1/29/13, indicated the following: Resident #39 was at risk for falls due to being over 80 years old, arthritis, use of anti-hypertensives, anti-convulsants, laxatives, impaired gait/balance, confusion, incontinence, a history of falls in the past 3 months and assistive devices. Resident #39's goal was to be free from fall related injuries. An approach for Resident #39 initiated 1/29/13, indicated there would be an alarming mat in front of her recliner. A physician's orders for Resident #39 indicated the following: " 1/30/13-Alarm mat in front of recliner. Special instructions: Indications			

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	decreased safety awareness. Fall risk." On 2/7/13 at 10:57 A.M., Resident #39 was observed seated in her recliner in her bedroom. She had some fading purple discoloration in the center of her forehead and under her right eye. Resident #39 indicated she could walk and did not need help getting out of bed. She had a skid mat under the legs of her recliner and another skid mat under her feet in front of her recliner. On 2/8/13 at 9:24 A.M., Resident #39 was observed seated in her recliner in her bedroom. She indicated she was waiting on her supper and she hadn't ate in 3 days. She displayed some confusion. She pointed at her wheelchair and indicated she was afraid to get in it because she felt she might fall. She had a skid mat under the legs of her recliner and another skid mat under her feet in front of the recliner. On 2/8/13 at 12:17 P.M., RN #6 indicated Resident #39 had an alarming mat lying on the floor by her bed but not in front of her recliner. She indicated the approach on the Resident #39's Care Plan indicating an alarming mat would be placed in			

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	front of the recliner needed to be clarified. On 2/8/13 at 1:56 P.M., RN #6 indicated she received clarification form the Director of Nursing (DoN) and the alarming floor mat should have been in front of Resident #39's recliner. A Fall Event Report for Resident #39 indicated the following: 2/10/13 at 9:41 P.M. Resident #39 had an unwitnessed fall. She was observed sitting up, dressed, with her shoes on in her room. Resident #39 indicated she was trying to go to bed. Interventions put into place to prevent another fall included she would be placed in bed after dinner. On 2/11/13 at 9:48 A.M., Resident #39 was observed seated in her recliner in her bedroom. She had a skid mat under the legs of her recliner and another skid mat under her feet in front of the recliner. CNA #7 indicated the alarming floor mat lying beside Resident #39's bed was utilized when she was in bed. She indicated the alarming floor mat was not used in front of Resident #39's recliner. An interview with LPN #1 on 2/11/13			

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	at 9:59 A.M., indicated Resident #39 used the alarming floor mat beside her bed and under her feet in front of her recliner. LPN #1 moved the alarming floor mat from next to the bed to under Resident #39's feet. Resident #39's Profile, utilized by staff, and provided by the DoN on 2/11/13 at 10:15 A.M., indicated Resident #39 would have an alarming floor mat in front of her recliner. On 2/12/13 at 9:14 A.M., Resident #39 was observed seated in her recliner in her bedroom. She remained confused. She stated "I'm thinking about going to Kentucky and living with my grandmother." A Fall Management Program policy and procedure provided by the Administrator on 2/12/13 at 3:25 P.M., indicated the following: "Procedure-4. Charge nurses will communicate the specific care required for each resident to the assigned caregiver on each shift.... 3.1-45(a)(2)			

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F0325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to notify the physician of a resident's significant weight loss and failed to implement any interventions to prevent weight loss for 1 of 3 residents reviewed for weight loss of 8 residents who met the criteria for nutrition (Resident #52). Finding include: Review of the record of Resident #52 on 2-12-13 at 9:00 a.m. indicated the resident's diagnoses included, but were not limited to, congestive heart failure (CHF), anxiety, paraplegia and multiple sclerosis (MS). Resident #52 was admitted to the facility on 8-24-12 and weighed 126 pounds. The resident's weight on 8-30-12 was 115; this indicated a 8.7 % weight loss in six days. The	F0325	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident # 52 no longer resides at the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practice**Licensed nurses were educated on notifying a Physician for any resident with a significant weight loss, and to implement interventions to prevent weight loss by the ED and DNS on 2/28/2013. All residents were reviewed for significant weight loss by the DNS/designee. No other residents were identified.Residents identified with a significant weight loss or gain will be reviewed in weekly NAR	03/05/2013

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	resident's weight on 9-23-12 was 116 pounds; this indicated a 7.9% weight loss in less than one month. The resident was discharged from the facility on 9-25-12. The physician order for Resident #52, dated 8-27-12 indicated the resident was ordered a low sodium regular diet. The Minimum Data Set (MDS) assessment for Resident #52, dated 8-31-12 indicated the resident was not on a physician prescribed weight loss regimen. The plan of care for Resident #52, dated 9-13-12 indicated the resident required a therapeutic diet due to CHF. The interventions were as follows: honor the resident's known food preferences that were within limitations of her diet restriction, to monitor the resident's food/fluid intake at meals, monitor the resident's weight, notify the Medical Doctor of any significant weight changes, offer the resident substitutes if less than 75% of any meal is consumed, provide the diet per Medical Doctor orders and review the resident's labs as available. The record of Resident #52 indicated		meeting to include weight history, current nutrition regimen, oral status, observations during meals, root cause, plan of care updated, and physician and responsible party were notified - to be attended by the DM, RD if available, DNS, RSM, MDS Coordinator, and/or Designees.Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses were educated on notifying a Physician for any resident with a significant weight loss, and to implement interventions to prevent weight loss by the ED and DNS on 2/28/2013. Residents identified with a significant weight loss or gain will be reviewed in weekly NAR meeting to include weight history, current nutrition regimen, oral status, observations during meals, root cause, plan of care updated, and physician and responsible party notified - to be attended by the DM, RD if available, DNS, RSM, MDS Coordinator, and/or designees. Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee	

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	155625	A. BUILDING 00 B. WING	02/12/2013

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	no documentation addressing the resident's significant weight loss. Interview with the Director of Nursing (DON) on 2-12-13 at 9:25 a.m. indicated the physician was not notified of Resident #52's weight loss. The DON indicated Resident #52's abdomen was swollen and it was felt the fluid from her abdomen was what had caused the resident's significant weight loss. The DON indicated there was no documentation or assessment completed of the resident's abdomen. The DON indicated there were no interventions implemented for the resident's weight loss. Interview with the Dietary Manager on 2-12-13 at 10:15 a.m. indicated nursing was responsible to notify the physician of Resident #52's significant weight loss. The Dietary Manager indicated Resident #52 was placed on a nutritional at risk committee when she was admitted to the facility because all new residents were placed on the committee. The Dietary Manger indicated there were no interventions put in place for the resident's significant weight loss. The weight policy provided by the Administrator on 2-12-13 at 11:15 a.m. indicated the nursing department		are responsible to ensure compliance**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The CQI audit tool for resident weights will be utilized weekly for 4 weeks then monthly for 6 months. ·Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	is responsible for identifying the resident with a significant unplanned weight loss/gain and meeting with the Dietary service Manager. The physician was also notified of significant or undesirable weight change. 3.1-46(a)(1)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to obtain a sleeping medication for 7 days after the medication was ordered, for 1 of 10 residents reviewed for medications. (Resident #A) Findings include: The record of Resident #A was reviewed on 2/7/13 at 9:24 a.m. Resident #A's diagnoses included, but were not limited to, MRSA (Methicillin-resistant-Staphylococcus Aureus), of the lungs, insomnia, pleural effusion (excess fluid between	F0425	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident A no longer resides at the facilityHow other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged deficient practiceLicensed nurses were educated on providing routine medications to residents per physician order, obtaining a script**	03/05/2013

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	the 2 pleural layers) and depressive disorder. Resident #A's MDS (Minimum Data Set), assessment, dated 1/15/13, indicated BIMS (Brief Interview for Mental Status). 15, a score of 13-15 indicating cognition intact. Resident #A's care plan, date 1/26/13, "Problem, Resident has diagnoses of insomnia and may become anxious or upset due to inability to sleep or lack of sleep. Goal, Resident will have less difficulty sleeping. Interventions, may become anxious or upset due to inability to sleep or lack of sleep, 1 staff to offer to walk through facility with resident to help resident feel tired and 2 staff to offer tub bath as this may help resident relax. Resident #A's physician's orders, dated 1/19/13, indicated "Ambien (insomnia medication) 10 mg (milligrams), by mouth, once a day at 8:00 p.m." Resident #A's nursing notes dated 1/24/13 at 1:09 p.m., indicated "Informed resident, nurse will contact physician again concerning pain issues. Resident also concerned with Ambien. Informed resident the		**timely for a controlled substance, notifing physician/alternative physician when medication is not available as well as responsible party per the DNS/designee on 2/28/13.All controlled substances will be reviewed to ensure that the meds ordered are available to residents timely, any medication found not available will have the attending Physician/alternate/pharmacy notified immediately by the charge nurse as well as the responsible party. This will be completed by the DNS and ADNS by 3/1/2013.All new orders for a controlled substance will be reviewed daily to ensure availability was timely by the IDT/designee.**Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were educated on providing routine medications to residents per physician order, obtaining a script timely for a controlled substance, notifing physician/alternative**	

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	physician did order the medication but has not sent in script to the pharmacy yet. Stated once that script is there, the pharmacy will deliver the meds to the facility. Informed resident, nurses have been calling her physician concerning script but unsure at this time if physician has contacted the nurse yet about the issue. Nurse states going to call resident's physician again today." Resident #A's MAR (Medication Administration Record), indicated Ambien, 10 mg, once a day was not initialed as given on 1/20/13 and 1/25/13. On 1/19/13, 1/21/13, 1/22/13, 1/23/13 and 1/24/13, reason not administered was documented as "drug/item unavailable." During an interview on 2/11/13 at 2:58 p.m., the DON (Director of Nursing) indicated "when we have a controlled substance order from the physician like Ambien it is only valid when the pharmacy is faxed. No order will be sent until a valid prescription or authorization is received from the physician. We don't always get a copy of the script but if we started the Ambien on 1/26/13 then that is when the pharmacy received the prescription."		**physician when medication is not available as well as responsible party per the DNS/designee on 2/28/13.All controlled substances will be reviewed to ensure that the meds ordered are available to residents timely, any medication found not available will have the attending Physician/alternate/pharmacy notified immediately by the charge nurse as well as the responsible party. This will be completed by the DNS and ADNS by 3/1/2013.All new orders for a controlled substance will be reviewed daily to ensure availability was timely by the IDT/designee.**Non-compliance with these procedures will result in further education including disciplinary action.DNS/designee are responsible to ensure compliance **How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The CQI audit tool for pharmacy services will be utilized weekly for 4 weeks then monthly for 6 months. ·Findings from the CQI process will be reviewed monthly by the Quality Assurance Committee and an action plan will be implemented for threshold below 90%.	

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	This federal tag relates to complaint IN00123230. 3.1-25(a)			